

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10174

10203

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 5 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SARA</b>	Middle <b>AUGUSTA</b>	Last <b>AHART</b>
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>30</b>	Year <b>19 59</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Marcus Fitch</b>		14. MOTHER'S MAIDEN NAME <b>Sara Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	INFORMANT <b>Eastern Shore State Hospital records</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome due to Senile Brain Disease, with psychosis</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr. 10, 1956</b> , to <b>Sept. 30, 1959</b> , that I last saw the deceased alive on <b>Sept. 30, 1959</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>E.S.S.H., Cambridge, Md.</b> <b>9/30/59</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>30 Oct 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>WOODLAWN</b>
22d. LOCATION (City, town, or county) <b>BRONX</b>		(State) <b>NY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LECOMPTE FUNERAL SERVICE</b>		24a. REGD. BY REGISTRAR <b>OCT 2 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Orthur J. Trahan</b>
ADDRESS <b>CAMBRIDGE</b>		DATE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10176

Items 11,12 FilmG248 9-21-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
Dorchester Maryland		Md					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reeds Grove		b. COUNTY					
c. LENGTH OF STAY IN lb 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reeds Grove					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle				
Margaret Estelle			Bell				
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (not months))	10. IF UNDER 1YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
Female	White			3/17/1886	73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Custodian		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
William Sisselberger		Minnie Ticehurst				17. INFORMANT	
						Mrs. Kenneth Sullivan, Glen Burnie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (d) stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		John Mace Jr.				9/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Burial		9/11/59		Woodlawn		Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John M. Mace Jr.		607 E. North Market		Sep 17 '59		Oscar L. Kimes	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10177

10193

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		d. STREET ADDRESS 27 Park Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alice		First	Middle	Last	4. DATE OF DEATH Sept. 14,	Month	Day Year 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1894	9. AGE (in years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Ward				14. MOTHER'S MAIDEN NAME Mary Jones Address Wade Bolden, Cambridge, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No							
16. SOCIAL SECURITY NO.							
17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Renal 442X DUE TO disease-Uremia Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus uncontrolled							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1959, to September 14, 1959, that I last saw the deceased alive on September 14, 1959, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		M.D. 227 Pine St.—Cambridge, Md. 9-20-59					
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/1959		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Bellanca</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Knudsen</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 Page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10194

## CERTIFICATE OF DEATH

10178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Worcester MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cambridge		1 week	
d. NAME OF HOSPITAL (If, not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge, Maryland		x East New Market	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1067			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Mary	Magdalene	Dickerson	9/22/1959
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	1/26/1925
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Canning factory employee		Maryland	U. S. A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Norman Jones	Bertha Coleman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)		Norman Jones, East New Market	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		5/5/59	
5/5/59		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Kremia	
{ (b)		Ch. Arthritis	
DUE TO		Hypertension	
{ (c)		5/5/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/9/59 to 9/22/59, that I last saw the deceased alive on 9/9/59, and that death occurred at 9/22/59, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
W. H. Hanks M.D.		184 Locust St 9/24/59	
PHYSICIAN'S NAME (Type)		Cambridge, Md	
22a. BURIAL, CREMATION, REMOVAL (SPECIMEN)		22b. DATE THEREOF	
Burial 9/25/59		22c. NAME OF CEMETERY OR CREMATORIUM	
22d. LOCATION (City, town, or county)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
Fulton, Millbury, East New Market		24b. REGISTRAR'S SIGNATURE Arthur H. Hanks	
VS A15 (4) 1SM 9/55			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
tem 18 Film 249 10-8-59 a.m.

10205

10179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 3, Seaford, Delaware		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERMAN		First F.	Middle DUKES
4. DATE OF DEATH September 18 1959		Lost	Month Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 7, 1903
9. AGE (In years from birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Willis H. Dukes		14. MOTHER'S MAIDEN NAME Roxie Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-8224 17. INFORMANT Mrs. Robert Hickman, RFD # 3, Seaford, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 971.1		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (b)		Unknown	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Alfred R. Maryanov		DATE SIGNED 9/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Caroline County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold W. Williams		24a. REC'D BY REGISTRAR DATE SEP 24 '59	
24b. REGISTRAR'S SIGNATURE Charles & Karp			

MANUFACTURED BY THE STATE OF MARYLAND  
OFFICE OF THE STATE CHEMIST

1000

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10205

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street/addr/ess) OR INSTITUTION <i>Barren Island.</i>		d. STREET ADDRESS <i>None.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Lawrence</i>	Last 4. DATE OF DEATH <i>9 19 1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1899</i>
9. AGE (in years last birthday) yrs. <i>60</i>	10. IF UNDER 1 YEAR Months <i>9</i>	11. IF UNDER 24 HRS. Days <i>19</i>	12. Year Hours <i>19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	
10c. BIRTHPLACE (State or foreign country) <i>United States</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alfred. Flowers.</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Hooper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>R. D. Hooper Flowers</i>		Address <i>Fishing Creek</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Heart failure.</i>			
DUE TO <i>Arteriosclerosis, arterioles, arteriole hypertension disease</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>—</i>			
(c) <i>—</i>			
INTERVAL/BETWEEN ONSET AND DEATH <i>1 hr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Stomach Cancer.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>9/19</i> p. m. <i>1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>9/13/1959</i> to <i>9/19/1959</i> that I last saw the deceased alive on <i>9/19/1959</i> , and that death occurred on <i>9/19/1959</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Fishing Creek, Md.</i> DATE SIGNED <i>9/20/59</i>			
ACTUAL SIGNATURE <i>Maurice I. Shub</i>			
PHYSICIAN'S NAME (Type) <i>Maurice I. Shub</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/22/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hoiser Mem.</i>		22d. LOCATION (City, town, or county) (State) <i>Fishing Creek, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE <i>SEP 22 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10195

## CERTIFICATE OF DEATH

Reg. Dist. No.

10182

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		d. STREET ADDRESS <b>201 Maryland Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge, Md. Hospital.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Phillip</b>		First	Middle <b>-</b>	Last <b>Kenny</b>	4. DATE OF DEATH <b>9 22 19 59</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/1907</b>	9. AGE (In years last birthday) <b>51</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Geo. Kenny</b>				14. MOTHER'S MAIDEN NAME <b>Lena <del>Adams</del> Ezley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Le Compte Funeral Service, Records.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO (c)		<b>Chronic nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diuretic list foot</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>1959</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1046 Locust St</b>		20f. (City or town) <b>Cambridge</b>		(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>59</b> , to <b>9/22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/22</b> , 19 <b>59</b> , and that death occurred at <b>1046 Locust St</b> , Cambridge, Maryland, from the causes and on the date stated above. ACTUAL SIGNATURE <b>W.H. Francis</b>						ADDRESS (Street, city or town, state) <b>1046 Locust St</b>		DATE SIGNED <b>9/23/59</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) <b>Cambridge, Maryland</b>		(State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles &amp; Anna</b>		



14  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the same date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Onancock</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>				d. STREET ADDRESS	
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Gordon</b>	Middle <b>Copes</b>	Last <b>Marsh</b>	4. DATE OF DEATH Month <b>Sept.</b>	Day <b>7</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1897</b>	9. AGE (In years on birthday) <b>62</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant owner</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>J. R. Gordon Marsh</b>		14. MOTHER'S MAIDEN NAME <b>Leda Edwards</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>C. D. Marsh, Onancock, Va</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Accomack</b>	(County) <b>Accomack</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>	EXAMINER'S NAME (Type) <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 7, 1959</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-9-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Holly</b>	22d. LOCATION (City, town, or county) <b>Accomack</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin Williams</i>	ADDRESS <b>17</b>	24a. REC'D BY REGISTRAR <b>SEP 10 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Anna</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

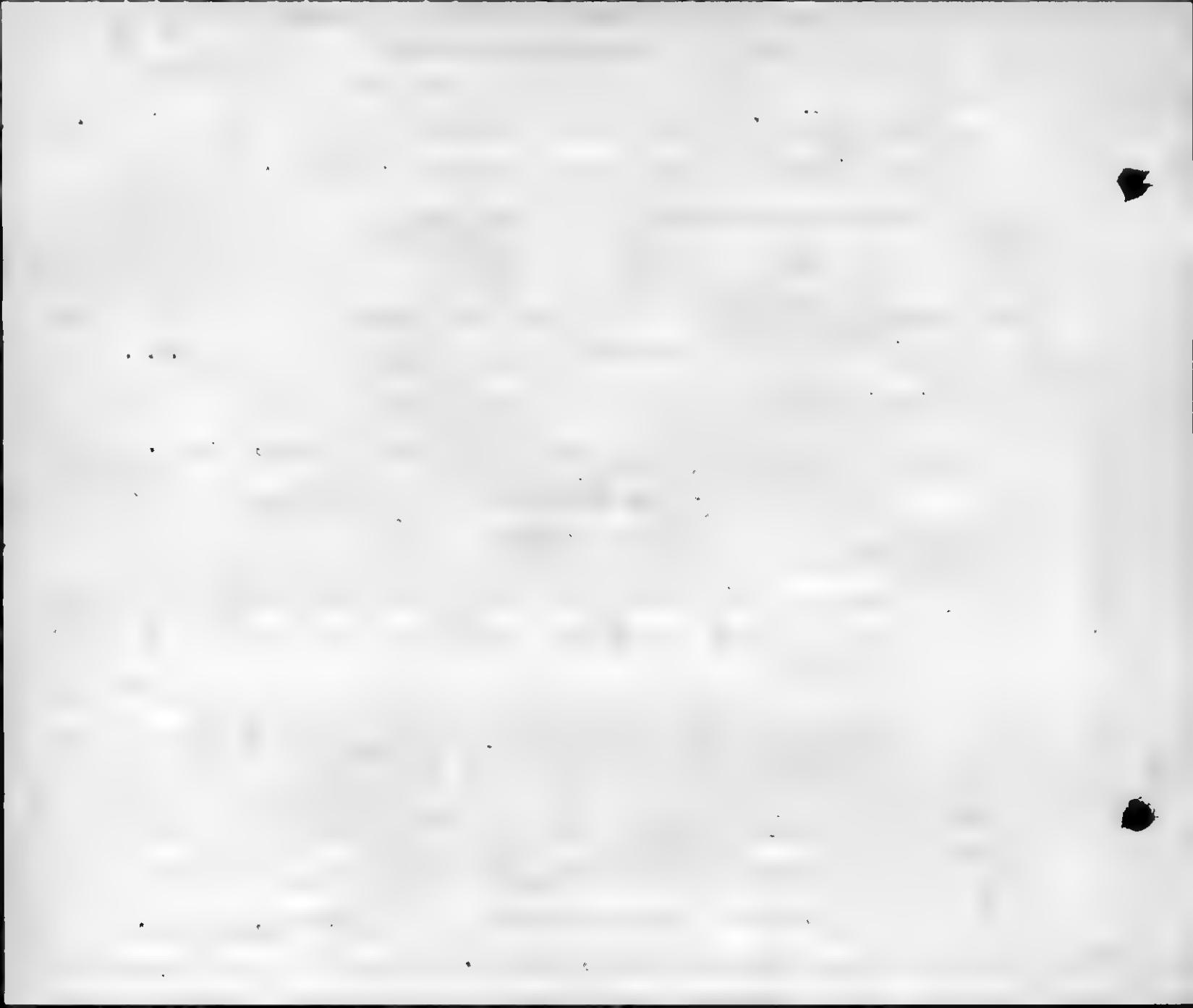
10207

## CERTIFICATE OF DEATH

Reg. Dist. No.

10184

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		b. COUNTY <b>Dorchester Co.</b>	
c. LENGTH OF STAY IN 1b <b>5 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddville, Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Malissa</b>		First <b>Murphy</b>	Middle <b>Murrell</b>
4. DATE OF DEATH Month <b>9</b>		Month <b>18</b>	Day <b>19</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/4/1878</b>		9. AGE (In years last birthday) <b>81 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Murphy</b>		14. MOTHER'S MOTHER'S NAME <b>Martha Todd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Le Compte Funeral Service, Records.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis, lumbar spine; Hypertension CVD</b>		?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. U. Thompson</b> REGISTRAR'S NAME (Type) <b>J. U. Thompson</b>		ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Zein Church Yard</b>		22d. LOCATION (City, town, or county) (State) <b>Toddville, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 22 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Orville E. Thompson</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10197

## CERTIFICATE OF DEATH

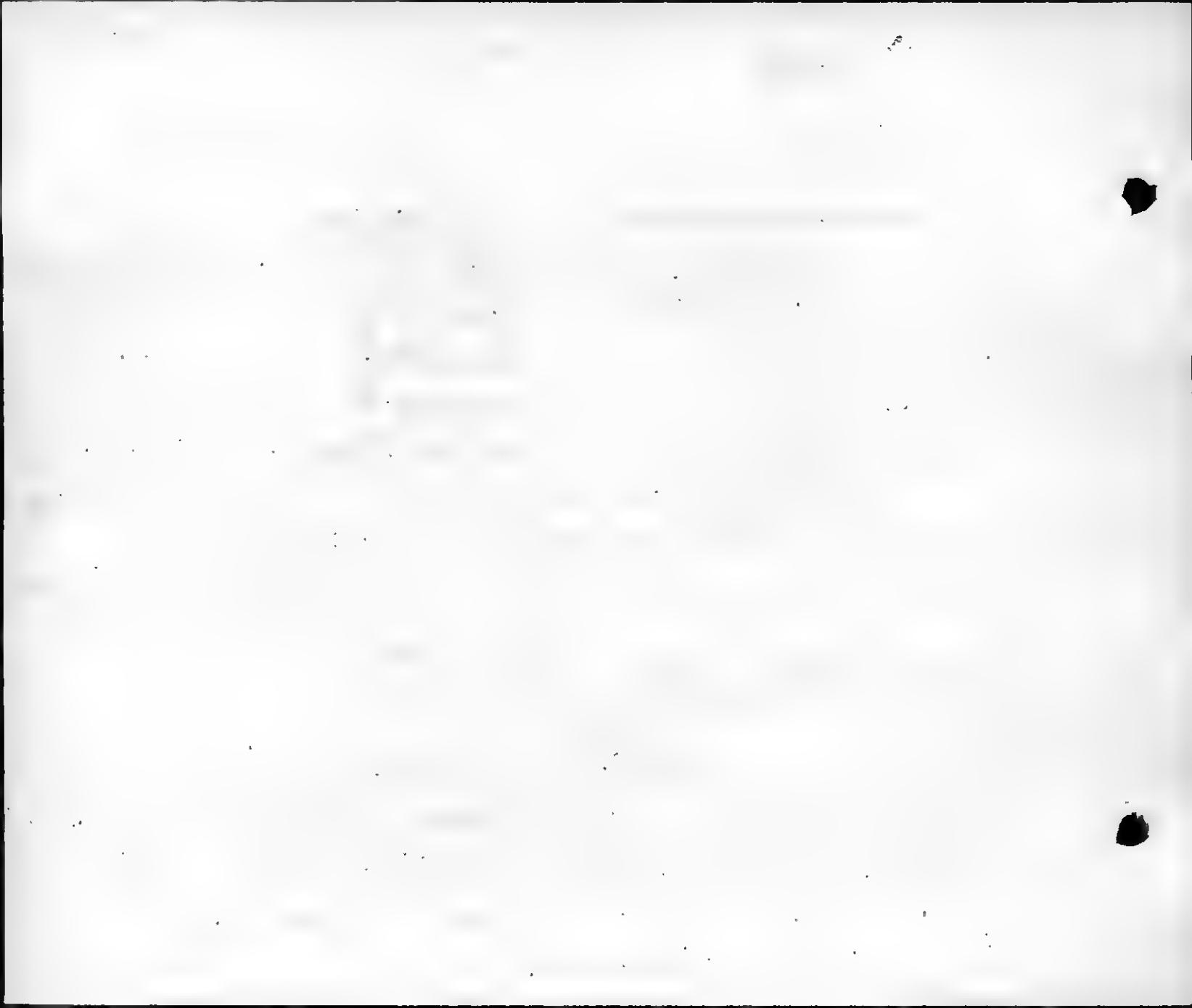
10185

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN Tb <b>entire life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>Calvert</b>	Last <b>Orem</b>
4. DATE OF DEATH	Month <b>Sept. 14, 1959</b>	Day 19	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fuel Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) Cambridge, R.D.</b>	
13. FATHER'S NAME <b>Calvert Orem</b>		14. MOTHER'S MAIDEN NAME <b>Emma Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. INFORMANT <b>E. Bayly Orem, 31 High St., Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO <b>Toxemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b) <b>Hemorrhages - Gastric ulcer.</b> DUE TO  (c) <b>Urinary Obstruction - Prostatic Operations</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Tumor Right Lung.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>59</b> to <b>9/14</b> , 19 <b>59</b> that I last saw the deceased alive on <b>9/14</b> , 19 <b>59</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>104 Locust St</b>			
ACTUAL SIGNATURE <b>W.H. Hanks, M.D.</b>			
DATE SIGNED <b>9/15/59</b>			
PHYSICIAN'S NAME (Type) <b>W.H. Hanks, M.D.</b>			
22a. BUR. AL. CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Christ Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Stewart</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 17 '59</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thorne</b>	



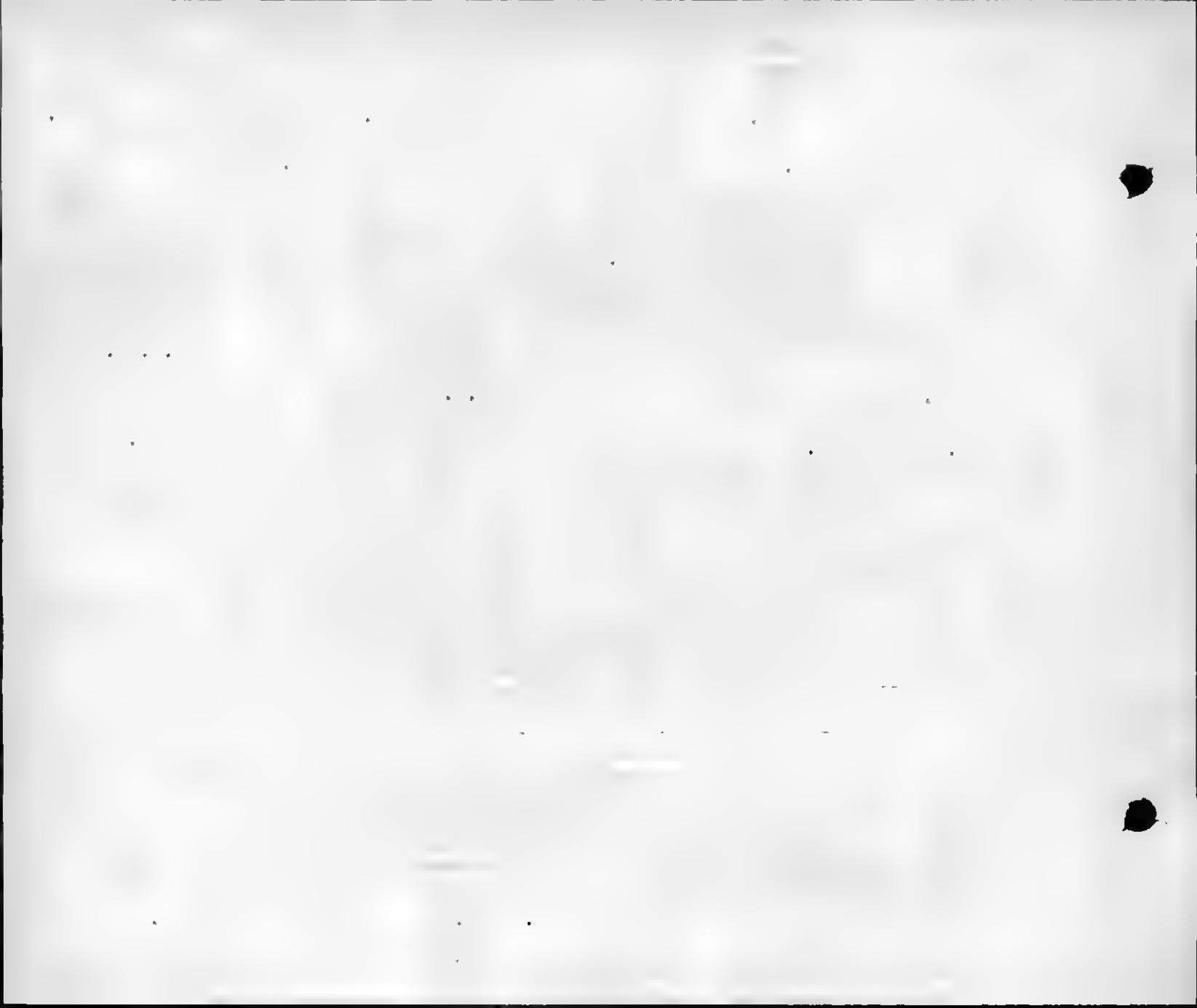
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		10203		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		d. STATE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Dorchester Co.		MARYLAND		Maryland.		b. COUNTY		Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Bishops Head, Md.		Life		Bishops Head, Md.		Bishops Head, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		None		d. STREET ADDRESS			
Bishops Head, Md.		d. STREET ADDRESS		None		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
		Ernest	L.	Ruark	9	7	19	59	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/18/1869	89				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Waterman		Waterman		Maryland		U.S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
M. Ruark		V.J. Winagate		No.		Unknown		Le Compte Funeral Service, Records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH			
331X		DUE TO				unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		arteriosclerosis, generalized		unknown			
DUE TO		(c)		--					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. -- -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Eldridge H. Wolff, M.D.						9-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/59		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park.		22d. LOCATION (City, town, or county) Cambridge, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		ADDRESS		24a. REC'D BY REGISTRAR SEP 10 1959		24b. REGISTRAR'S SIGNATURE Arthur & Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.



1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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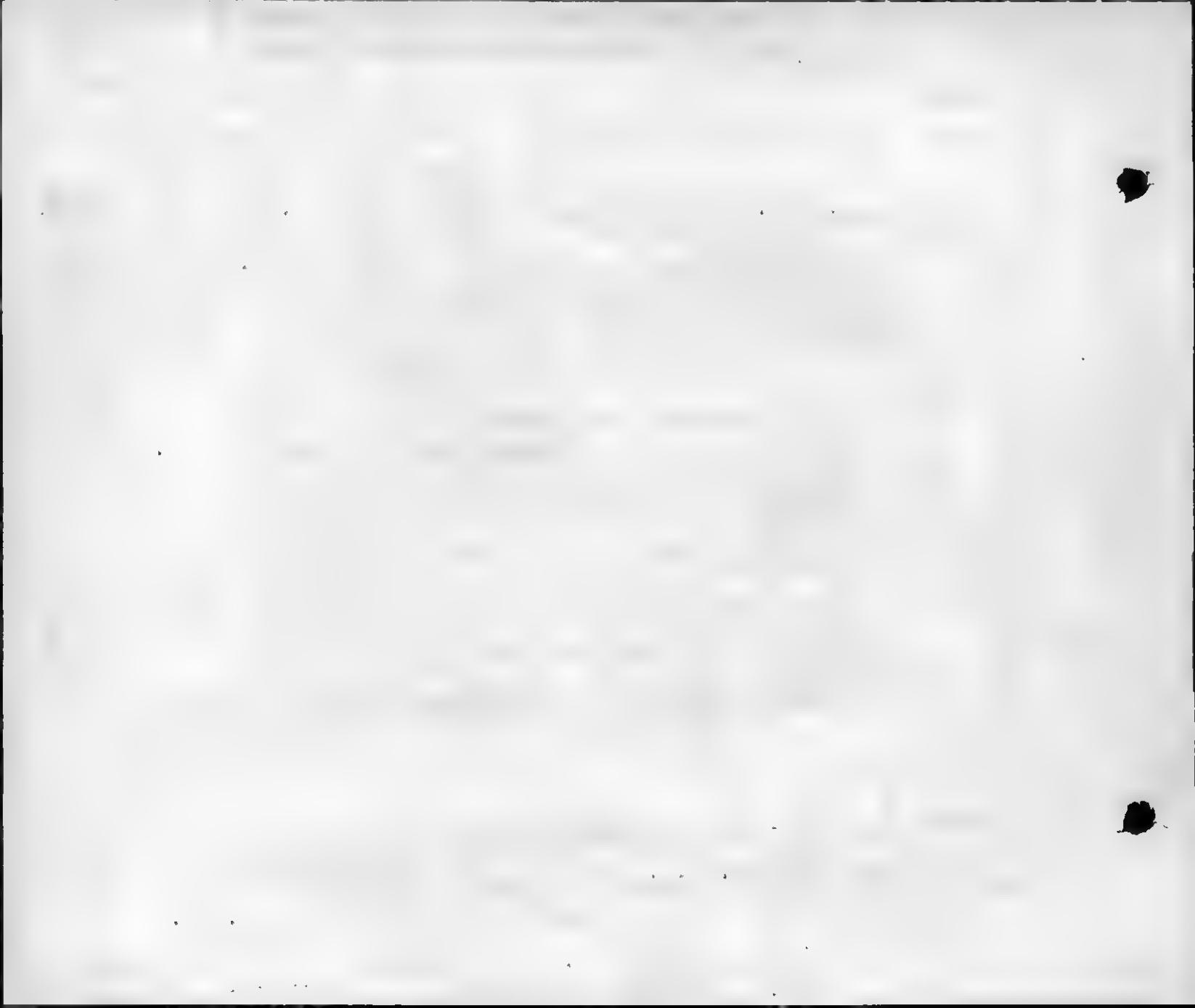
10187

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS Moores Ave. Ext.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Moores Ave. Ext.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NOW <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Linwood		First	Middle	Last	4. DATE OF DEATH Sept. 8 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/1900	9. AGE (In years at birth) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jake Sampson				14. MOTHER'S MAIDEN NAME Ella Sampson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Spruill Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH ?		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/10/59		
EXAMINER'S NAME (Type) John Mace Jr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/59		22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery		22d. LOCATION (City, town, or county) Salem, Dor. Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10199

## CERTIFICATE OF DEATH

Reg. Dist. No.

10188

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write nearest town) CAMBRIDGE		b. COUNTY DORCHESTER	
c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.		d. STREET ADDRESS RFD # 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANCES	Middle R	4. DATE OF DEATH Month SEPT 29, Day Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 27, 1907
9. AGE (In years last birthday) 51 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done) LPHOTO TYPE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK ROBERSON		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT BECKWIRTH ROBERSON		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Aneurysm	
(b) DUE TO		Arteriosclerosis	
(c) DUE TO		Essential Hypertension	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2, 1959, to 9/29, 1959, that I last saw the deceased alive on 9/29, 1959, and that death occurred at 8:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Hawks</i>		ADDRESS (Street, city or town state) M.D. 104 Locust St. CAMBRIDGE MD. DATE SIGNED 17/1/59	
PHYSICIAN'S NAME (Type) W.H. HAWKS			
22a. BURIAL/CREMATION REMOVAL (Specify) BURIAL		22b. DATE OF DEATH OCT 2, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL DORCHESTER MEMORIAL PARK		22d. LOCATION (City, town, or county) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTÉ FUNERAL SERVICE		24a. REC'D BY REGISTRAR DATE OCT 2 '59	
ADDRESS CAMBRIDGE MARYLAND		24b. REGISTRAR'S SIGNATURE <i>W.H. Hawks</i>	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10189

10200

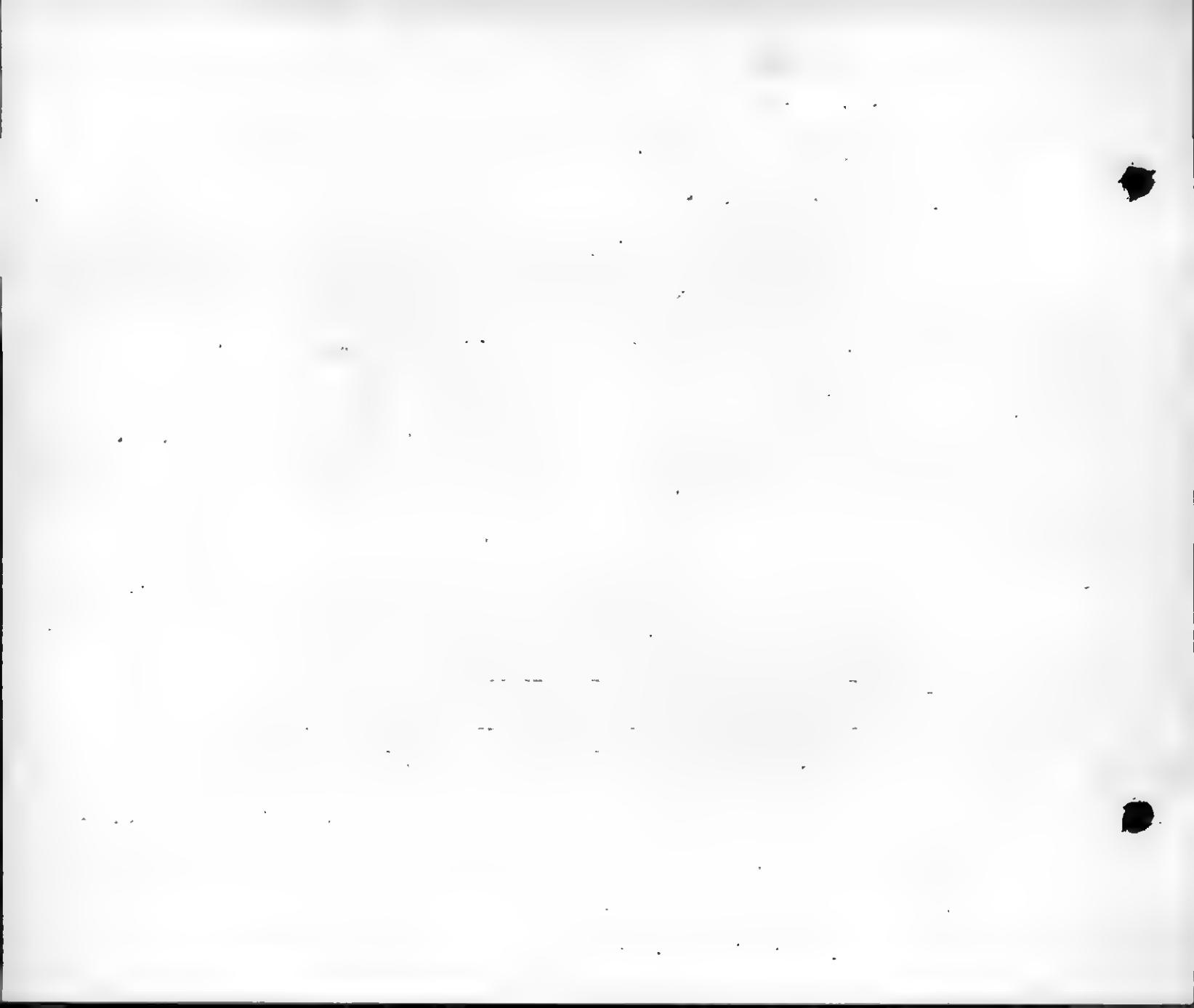
## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smyrna	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Edward	Middle Stevens
Last Stevens		4. DATE OF DEATH September 6 1959	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1877
9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac E. Mills		14. MOTHER'S MAIDEN NAME Sarah German	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT		Address William P. Mills, East New Market, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) Myocardial infarction			
DUE TO			
(c) Arteriosclerotic cardio vascular renal disease			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
terminal bronchio pneumonia			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-30-59, 19, to 9-6-59, 19, that I last saw the deceased alive on 8-30-59, 19, and that death occurred at 5:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff, M.D.		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md., 9-8-59	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery		22d. LOCATION (City, town, or county) Near Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE SEP 10 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles E. Keene	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10201

## CERTIFICATE OF DEATH

Reg. Dist. No.

10191

1. PLACE OF DEATH a. CITY OR TOWN DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE CAMBRIDGE		b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 16 9 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		d. STREET ADDRESS 13 406 RACE STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP.				d. STREET ADDRESS 13 406 RACE STREET		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ROBERT	Middle J	Last WALLER	4. DATE OF DEATH SEPT.	Month * * * * *	Day 13	Year 1959	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1903	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME W J WALLER				14. MOTHER'S MAIDEN NAME JENNIE WILLIAMS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217 09 9196		17. INFORMANT MRS ROBERT WALLER		Address CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO C� lying cause last. (c)				Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 136 Race St.		(County)	(State)
21. I certify that I attended the deceased from 9/10/59, 19, to 9/13, 1959, that I last saw the deceased alive on 9/13, 1959, and that death occurred at 8:27 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.						ADDRESS (Street, city or town, state) 136 Race St.		DATE SIGNED 9/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF SEPT. 15, 1959		22c. NAME OF CEMETERY OR CREMATORIAL WICOMICO MEM. CEMETERY		22d. LOCATION (City, town, or county) SALISBURY MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMpte FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HABER - BARNHORN - 17

CERTIFICATE OF DEATH

10501

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11331

Reg. Dist. No.

10202

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 25 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 128 Pine St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
3. NAME OF DECEASED (Type or print) William Chandler West		d. STREET ADDRESS 128 Pine St.			
4. DATE OF DEATH Sept. 27 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1864		
9. AGE (In years last birthday) 94 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired minister	11. KIND OF BUSINESS OR INDUSTRY Church	12. BIRTHPLACE (State or foreign country) Delaware		
13. FATHER'S NAME Henry W. West	14. MOTHER'S MAIDEN NAME Nancy C. Vincent	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.	17. INFORMANT Beatrice West 128 Pine St. Camb. Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident.</u> INTERVAL BETWEEN ONSET AND DEATH 33/X Instant					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)			
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/29/59		
EXAMINER'S NAME (Type) Dr. John Mace Jr.	22b. DATE THEREOF 9/29/59	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Dor., Md.		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE NOV 5 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frazee</i>	

